FLORIDA'S HEALTH CARE CERTIFICATE OF NEED

Authors:

Marshall B. Kapp, J.D., M.P.H.
Director, Florida State University
Center for Innovative Collaboration in Medicine and Law

Leslie M. Beitsch, M.D., J.D.
Chair of Medical Humanities and Social Sciences and Director,
Division of Health Affairs, Florida State University College of Medicine

Published January 2014

HEALTH FOUNDATION of south florida

Is Florida's Certificate of Need (CON) Program Necessary?

Introduction

The Certificate of Need (CON) program can be traced to 1964 in Rochester, New York, where a community health planning council composed of health care consumers, insurers, and providers was formed to study the need for hospital beds. The efforts of this group to monitor the number of health care facilities based on assessments of community needs resulted in New York's passage of the nation's first Certificate of Need law in 1966, the Metcalf-McCloskey Act.

In 1972, the federal government amended Section 1122 of the Social Security Act to require all states to review health care capital expenditures in excess of $100,000. This provision served as the precursor to Congressional enactment of the 1974 National Health Planning and Resources Development Act.[1] This Act made state CON programs mandatory as a condition of receipt of federal health planning dollars and included guidelines for CON review. Every state that did not already have a CON program in place adopted its own CON regulations in response to the federal incentive.

The momentum (and accompanying funding) for a national approach to health planning faded in the 1980s and federal health planning legislation was repealed in 1986. Since then, a number of states have either entirely revoked or substantially cut back their CON requirements. A list prepared by the National Council of State Legislatures detailing the 2011 status of CON laws in individual states appears on pages 15-18.

The Florida CON program was established in 1973, largely as a means of allowing the state government to more uniformly control the health planning process; previously, federal health planning dollars went directly to regional health planning councils without state-level oversight or involvement. A version of CON continues in Florida today. The continuing value of the Florida CON program is a debated and controversial topic. The purpose of this Policy Brief is to provide an objective summary description of Florida's current CON program and the main arguments pro and con about maintaining the program in its present form. Specifically, this document addresses the following questions of interest:

- What is Florida's CON program?
- What does the Florida CON law cover and what process governs CON applications in Florida?
- What were the original goals of the Florida CON program?
- Are those original goals being achieved in Florida presently?

- Is a CON program necessary in Florida today? What arguments support continuation or discontinuation of the program?
- What can we learn from other states that have eliminated their CON programs?
- If CON continues in Florida, what changes (if any) should be made in the law?
- What is the potential impact of the federal Affordable Care Act on the Florida CON program?

To prepare this Brief, the authors researched and reviewed relevant Florida law and pertinent published literature and reports. Additionally, individual structured interviews were conducted with more than a dozen key informants representing the perspectives of state government (administrative agencies and courts), trade associations, and private legal practice. Further, e-mail contact was attempted with a representative of each of the states that have eliminated CON programs to inquire about the effects of such program elimination.

What is Florida's CON Program?

Florida's CON program has been administered by the Agency for Health Care Administration (AHCA) since AHCA's creation in 1992, through its Florida Center for Health Information and Policy Analysis. CON administration is a regulatory process governed by Florida Statutes §§ 408.031 through 408.045 and Florida Administrative Code Chapter 59C-1. This process requires certain health care providers to obtain state approval before offering new or modified services. A state's constitutional authority to impose a CON requirement on health care providers has been upheld by the federal courts.[2] In terms of project approval, the Florida CON program operates completely at the state level, following the 1982 elimination of local Health Systems Agencies and their local CON review function in Florida, although monitoring of CON-approved project development does occur at the local level via the regional health planning councils.

Florida CON Program Coverage and Process

The coverage of Florida's CON program has been substantially reduced since the program originated. Items originally subject to CON review but subsequently eliminated by the Florida legislature include, among others:

- New or expanded Obstetrical services
- Outpatient project capital expenditures
- Acquisition of medical equipment
- New or expanded Medicare-certified Home Health Agencies
- Cost overruns of approved projects of any kind
- New rural hospitals meeting certain criteria

- Addition or delicensure of acute care beds, neonatal intensive care beds, hospital-based skilled nursing home beds, long-term care hospital beds, and inpatient hospice beds at existing facilities
- New or expanded adult open heart surgery programs
- New or expanded burn units

Currently, Florida CON program coverage is limited to:

- New hospital facilities
- Replacement hospitals proposed to be built more than one mile from the hospital being replaced
- Neonatal Intensive Care Unit (NICU) Level II and III beds, unless exempt under Florida Statutes § 408.036(3)(l)
- Comprehensive medical rehabilitation beds
- New Long-Term Care Hospitals
- Pediatric open heart surgery beds and services
- Pediatric cardiac catheterization services
- Organ transplantation services
- New nursing home beds. (In 2001, the Florida legislature placed a moratorium on the issuance of CON for additional community nursing home beds until July 1, 2006. In 2006, the legislature extended the moratorium until July 1, 2011. In 2011, the legislature extended the moratorium until Medicaid managed care is fully implemented [anticipated approximately April , 2014] or October 1, 2016, whichever is earlier.)
- Replacement nursing homes if more than three miles from the nursing home being replaced
- New hospice programs
- New hospice inpatient facilities
- Intermediate care facilities for the developmentally disabled

To illustrate the deregulatory evolution of the Florida CON program, at one time AHCA employed more than 40 full-time staff dedicated to CON review; today, four full-time staff is adequate for that role. In 1985, AHCA reviewed and acted upon 542 CON applications; in 2010, the total was 39 CON applications, with a total of 29 expected for 2013. The number of challenges to CON applications that reach the Florida Division of Administrative Hearings (DOAH) for adjudication today has greatly diminished compared with years past.

AHCA reviews applicable hospital CON applications twice a year and issues decisions in June and December. Other applications also are reviewed twice a year, with decisions made in February and August. Certain reviews qualify for expedited treatment at any time. Certain exempt beds (including conversions of licensed acute care beds to Medicare- and Medicaid certified skilled nursing beds in rural hospitals and the construction of inmate health care facilities and state Veterans homes) may be added by notification to AHCA. Additionally, the Florida legislature occasionally acts to afford special treatment under the CON program, as well as under facility licensure

standards, for particular proposed projects. For instance, in 2013 the legislature enacted House Bill 1159[3] which, besides other provisions, expedited the CON review process for nursing home beds in The Villages.[4] House Bill 1159 also explicitly enabled Miami Children's Hospital to add obstetrical beds for mothers of high risk fetuses[5] without complying with the usual licensure standards governing adult hospital beds.

A number of informants commented that, since all CON contested application hearings were moved to Tallahassee several years ago ("out of the public eye"), the interest and involvement of the general citizenry in the CON process appears to have waned markedly. When hearings were held in the past in the geographic areas directly affected by a CON application, the local media was involved and a solid showing of general citizens at the hearings was common, but that level of local media and citizen interest has diminished.

Original Goals of the Florida CON Program

In 1973, Florida enacted its CON program as a policy-driven response to the perceived failures of unbridled competition. There is broad consensus that the primary reason for establishing the CON program in Florida (and in other states at the time) was to moderate the growth of health care expenditures (especially in the governmental Medicare and Medicaid programs that reimbursed providers on the basis of providers' costs) by controlling unnecessary duplication of health care facilities and services. At that time, the state was beginning to experience an enormous population growth and the health care infrastructure in place to accommodate the burgeoning population was quite undeveloped. There were concerns that, in the absence of a comprehensive regulatory scheme, the growing supply of inpatient beds and other expensive health care services driven solely by market forces would exceed demand in many local areas, resulting in excess capacity and thus increased health care costs. Meanwhile rural areas and other underserved communities would remain underdeveloped in terms of available health services.

Two additional goals undergirded the original Florida CON program: access and quality. The CON program was designed to assure all Floridians, regardless of insurance or socioeconomic status, equitable access to health care services and facilities. To achieve this goal, the CON regulatory process seeks to establish an appropriate capacity for the regulated provider types through a comprehensive review process based on state planning standards. In setting these planning standards, AHCA must consider, at a minimum, the following:

- The demographic characteristics of the population;
- The health status of the population;
- Service use patterns, standards, and trends;
- Geographic accessibility to needed services; and
- Market economics[6]

Also, although it was not specifically delineated as a criterion that must be considered by the regulatory agency, the creators of the Florida CON program presumed that the regulatory review process would play a valuable role in assuring the quality of those facilities and health services ultimately approved. By controlling the proliferation of unnecessary facilities and services, it was expected that CON could prevent human and other resources from being spread so thin that quality might suffer.

Are the Original Purposes of the Florida CON Program Being Achieved Today?

Whether the original purposes of the Florida CON program (namely, cost containment, equitable access, and quality) are being achieved by the program currently is a controversial question. Proponents of continuing the CON program in, or close to, its present form strongly contend that the original goals are consistent—even synergistic—with each other, well served by the present CON program, and that further legislative constriction or elimination of the program would seriously endanger the program's fundamental goals. The current program proponents are comprised primarily of representatives of the still-regulated industries—hospices, hospitals,[7] and nursing homes.[8] Conversely, informants coming at the question from a different set of perspectives generally are considerably more skeptical about the present success of the Florida CON program in realizing and promoting the program's original purposes. As indicated below, these skeptics suggest that the purported purposes of CON might be better promoted by alternative strategies. Limited available data support either position.

Is a CON Program Still Necessary in Florida Today?

The continued value of Florida maintaining a health care CON program in 2013 and beyond is an issue over which the key informants to this study largely disagree. This section lays out the contrasting positions.

Pro

The philosophical and political touchstone for advocates of continuing the status quo is a deep distrust of the unregulated free market to serve the goals of cost containment, equitable access, and quality assurance within the health care sphere, at least within the specific industries still regulated under the Florida CON program. According to representatives of the regulated industries, further legislative constriction or elimination of the CON program, or premature termination of the nursing home bed moratorium, would likely result in an explosion in Florida of new hospices and increases (some informants speculated about a "flood") in the number of new hospitals and nursing homes. This explosion would increase the escalation of health care spending, diminish adequate access for already underserved populations, and threaten the quality of care provided by providers in the regulated industries. It would also strain a limited workforce in certain specialty areas, such as transplantation, and even primary care.

According to this viewpoint, health care providers do not and cannot operate in a true free market because they are very dependent on government financial payments (mainly through Medicare and Medicaid) at rates essentially set unilaterally by government at the federal and state levels. Moreover, providers do not have the right to freely pick and choose their consumers, as would occur in a real free market. For example, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospital emergency departments to evaluate and stabilize any person presenting to the department, regardless of insurance or financial status,[9] as does Florida law.[10] A Florida nursing home may not transfer or discharge a resident just because the resident converts from private pay or Medicare status to Medicaid coverage.[11]

Further, Florida now has more than four million uninsured people for whom nobody is actively competing. A marketplace driven exclusively by the profit motive would, it is argued, fail to provide meaningful access to services for this population. The "glaring market imperfections" cited by the regulated industries are echoed by the main organization comprised of health planning professionals, which has pointed to

> …the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively-imposed service mandates, cross-subsidization within the system, and service to all in urgent and emergency circumstances regardless of ability to pay.[12]

CON proponents argue that the probable proliferation of boutique hospitals that siphon off insured and wealthy patients from existing facilities would destroy the ability of existing facilities to continue using their insured and wealthy patients to cross-subsidize services for the uninsured and otherwise exert a negative impact on access.[13] This claim must be considered in light of legislation enacted in 2004 prohibiting in Florida the development of any specialty hospitals focused on cardiac, cancer, or orthopedic care.[14]

It is argued that removing the hospice industry from the CON program likely would result in a proliferation of home health agencies rapidly entering into a competition with hospices for business, a development that would threaten patients needing hospice services with poor quality care. We also, it is argued, should be concerned about the possibility of fraudulent home health care businesses coming into being to compete for hospice payments.

If nursing home beds increase, so, too, inevitably would the state's Medicaid expenditures since most nursing home bed days are paid under the Medicaid program on a cost basis. There is a fear that access to nursing home beds by the poor might be endangered in a state like Florida in which the overwhelming majority of beds are already in for-profit facilities. Because it costs approximately $250,000 to build a new nursing home bed in Florida and it is difficult to recoup those costs through Medicaid

payments, it was posited by CON proponents that elimination of the CON program for this industry would mean that the only new nursing home beds built in this state would likely be dedicated to Medicare and private pay residents. Apprehension was expressed that some of the new for-profit nursing homes that would bloom in the absence of CON or a moratorium might be willing to operate at a financial loss for a few years in order to drive non-profit, mission-based facilities out of business by competing vigorously for both staff and residents.

Another facet of access concerns the mix of services and providers available to consumers. Some key informants suggested that the moratorium on new nursing home beds presently in force deserves most of the credit for the salutary growth of home- and community-based long-term care services and supports throughout Florida during the past decade, as a viable alternative to nursing home placement. Nonetheless, Florida still trails many other states in the full range of plentiful options available for long-term care in many regions.

In terms of quality, proponents of the CON program contend that, in light of evidence that there generally is a positive correlation between the volume of particular services provided and the maintenance of skills and positive outcomes,[15] the constriction or elimination of CON requirements might result in services being spread out among so many different providers that particular providers will lack sufficient volume experience to maintain quality. Furthermore, Florida is plagued already by severe shortages and maldistribution of needed health care professionals; if CON were substantially cut back of eliminated, it is contended, the resultant bidding war for medical and support personnel would make it impossible for some providers who mainly serve the uninsured to compete for needed personnel (thus diminishing the quality of care available through those providers), or at the least would raise the overhead costs for providers who can successfully hire and/or retain in-demand health care workers. A particular challenge for hospices is presented by the significant reliance of providers in this field on volunteers; concern was expressed that a proliferation of new hospices fed by repeal of the CON program might imperil the quality of hospice care by spreading the pool of available volunteers too thinly.

Proponents of the present Florida CON program also cited in support of their position significant present uncertainty in the whole health care system occasioned by such factors as implementation of the federal Affordable Care Act[16] and implementation of Medicaid managed care at the state level. They contend that the confusion and chaos engendered by further constriction or elimination of the Florida CON program at this moment would threaten serious damage to the financial stability of the current health care enterprise and its ability to maintain an adequate workforce in the face of an uncertain future.

Con

By contrast, informants representing non-industry perspectives were overall much more ambivalent about future continuation of the status quo regarding CON in Florida.

Some of the non-industry informants expressed faith (albeit unsupported by Florida-specific data) that the CON program may at least partially promote some of the program objectives. Most of these informants, however, point to the absence of data about program benefits in the face of substantial data about program costs, including the protection of providers that effectively limits choices for consumers.[17]

A number of informants opined that several aspects of the current health care system that were not important factors earlier now argue for continuing to evolve away from our dependence on a CON program to perform the functions of containing costs and promoting better access and quality. These factors collectively pointing toward a greater rationalization in the distribution and delivery of health resources include: a much stricter and better enforced state licensure regime for health care providers; a financial marketplace that, as a matter of practical economics, discourages entities from frivolously proposing new facilities or expanding capacity in the absence of due diligence really indicating the likelihood of realizing a profit on a necessarily enormous investment; a Medicare and Medicaid system in which the federal and state governments, respectively, unilaterally set reimbursement rates; private insurers' restrictive payment policies "levering" provider behavior; workforce shortages that discourage the proliferation of new or expanded facilities and services; and the United Network for Organ Sharing (UNOS)[18] controlling the allocation of organs for transplantation purposes. A further observation shared by several informants is that the CON program will become increasingly unimportant as the bulk of health delivery continues to rapidly move from regulated inpatient to unregulated outpatient settings.

Even the strongest advocates of repealing Florida's CON requirement as wasteful and unnecessary, or even counterproductive, do not envision such repeal occurring in the foreseeable future. Although the general political/philosophical tenor of Florida state government might be receptive to the idea of repeal, individual legislators are heavily influenced by their own constituents who are members of the regulated industries and tenaciously defend the status quo. No state government official in Florida has embraced, or is likely to soon embrace, CON elimination as an appealing political rallying cry.

What Can We Learn from Other States that Have Eliminated Their CON Programs?

Fourteen states have eliminated Certificate of Need programs. These states and their dates of CON program elimination are:

- Arizona (1985) (still retains CON requirement for ambulance service providers only)

- California (1987)
- Colorado (1987)
- Idaho (1983)
- Indiana (1996, and again in 1999)
- Kansas (1985)
- Minnesota (1985)
- New Mexico (1983)
- North Dakota (1995)
- Pennsylvania (1996)
- South Dakota (1988)
- Texas (1985)
- Utah (1984)
- Wisconsin (2011)
- Wyoming (1989)

Informal Assessment of State Officials

In the states that have eliminated CON, the passage of substantial time since program elimination (Wisconsin is the only state where CON elimination occurred during the past decade) coupled with staff turnover translates into lack of much institutional memory among present regulators for comparing the pre- and post-elimination situations. Nonetheless, the general consensus among those state officials in the fourteen non-CON states who responded to the authors' inquiry is summarized well by one respondent:

> I have been asked many times about the effects of repeal of ***'s Certificate of Need program. Talking with other states, it appears that our changes [in the healthcare delivery system] are similar to other states regardless of whether a CON program exists. I do not see that the repeal of the CON program could be correlated with changes. It appears to me that there have been other variables which are likely more responsible for changes. These would include population shifts, the aging of the population, aging and outdated health care infrastructure, new medical technology, merger of providers, and state and federal funding shifts that include some moratoriums. I cannot speak to healthcare costs. My guess is that state costs would likely be the result of an aging population, new technology, and increases in fees for services.

Published Literature

Very few rigorous studies have been conducted analyzing the impact on healthcare costs, access, and quality brought about by the legislative elimination of the CON program in particular states. For example, a 2006 report of the California Research Bureau documents the demise of the California CON program, but does not evaluate the impact of that demise.[19] Moreover, most of the sparse available research

findings are not recent. With those caveats, however, there is some limited evidence to consult. Proponents of continued CON programs in Florida and elsewhere point to the following published statements:

- "Ohio…dropped CON requirements for all services except nursing homes in 1998. Ohio experienced an explosion of new ambulatory surgery centers and imaging centers immediately after the CON requirements for these services were eliminated. After removing most CON coverage in Ohio, the state has seen construction of 150 additional surgery centers and 300 additional diagnostic imaging centers."[20]
- "Following the repeal of Texas' CON law, the state saw a surge of new 'boutique' and physician-owned hospitals that spawned a dramatic rise in costs."[21]
- In 2006 in McAllen, Texas, Medicare spent over $15,000 per enrollee—twice the national average.[22] (However, in El Paso, Texas, costs were one-half of those in McAllen, suggesting that lack of a state CON program did not explain McAllen's high costs.)[23]
- Studies conducted by the three major American automakers examining the period 1996 to 2001 found that their health care expenses for employees in states without a CON program significantly exceeded healthcare expenses for employees in states with a CON program.[24]

Assuming the Continuation of the Florida CON Program, What Changes (If Any) Should Be Made?

None of the informants interviewed for this report advocated expansion of current CON coverage in Florida, with the exception of one person who speculated about the possibility of including Assisted Living Facilities (ALFs), which now are not even licensed as health care providers.[25] Others rejected the idea of expanding the CON program to regulate ALFs, on the grounds that it would be incorrect to impose that level of regulation on an industry that is essentially private pay.

A few other suggested changes to current Florida CON law were of a technical nature, specifically:

- Updating the boundaries of the Health Planning Districts and Sub-Districts drawn in the 1970s to reflect population shifts and changes in distribution of health services, resulting in fewer, larger Districts
- Updating the formula for computing nursing home bed needs to recognize the aging of the state's population and the consequent need for more nursing home beds
- Increasing the active role of Health Planning Councils in regional development planning, given the importance of the built environment in producing health outcomes

Other suggested methodological changes are embodied in Florida Senate Bill 268, introduced on October 14, 2013. S.B. 268 would amend CON methodology for determining the need for nursing home beds to encourage the modernization—renovation and replacement—of older nursing home facilities, the movement of beds among facilities, plus the construction of a limited number of new beds. Supporters of S.B. 268 contend that financial lenders are wary about lending to builders of Medicaid nursing home beds, but that the CON program (by restricting competition from new nursing homes that will only skim off Medicare and private-pay residents) gives lenders a greater sense of security about lending to builders of Medicaid nursing home beds. Without a CON program providing that sense of security, the cost of borrowing money to renovate and replace facilities serving the Medicaid population would increase substantially. According to S.B. 268 supporters, that is what happened in Texas after elimination of CON for nursing homes, resulting in many nursing homes there that served the poor being driven out of business by new facilities serving a wealthier resident population.

What is the Potential Impact of the Affordable Care Act (ACA) on the Florida CON Program?

Research has revealed no published literature linking the ACA and CON, in general or specifically in Florida. Few of the informants interviewed discerned any such connection, at least directly and immediately. The limited speculation about a potential relationship between the ACA and the Florida CON program centered on the following ideas:

- The ACA is likely to motivate or facilitate health provider behavior that encourages the delivery of more patient care on an outpatient basis, rather than within hospitals and nursing homes currently regulated by the Florida CON program.
- To the extent the ACA (by, for example, incentivizing the creation of Accountable Care Organizations or ACOs) encourages mergers, acquisitions, and other forms of consolidation within the health care industry in an effort to deliver care more efficiently, there are likely to be fewer CON applications for new hospitals, nursing homes, and hospices.
- The ACA may motivate hospitals to attempt to build new comprehensive rehabilitation beds in an effort to control the costs of whole episodes of care. These beds would serve many of the same patients who otherwise would be discharged from hospitals to nursing homes. It is unlikely that CON applications for new comprehensive rehabilitation beds would be granted if AHCA determines that sufficient nursing home beds already exist.
- We should resolve to formally review the impact of the ACA on the CON program at a designated future time.

Is Florida's Certificate of Need (CON) Program Necessary?

This policy brief was commissioned by the Health Foundation of South Florida for the purpose of providing an informative and educational overview of Florida's CON program in 2013. The authors are the Florida State University Center for Innovative Collaboration in Medicine and Law and the Florida State University College of Medicine Division of Health Affairs.

Authors:
Marshall B. Kapp, J.D., M.P.H., Director, Florida State University Center for Innovative Collaboration in Medicine and Law
http://med.fsu.edu/medlaw

Leslie M. Beitsch, M.D., J.D., Chair of Medical Humanities and Social Sciences and Director, Division of Health Affairs, Florida State University College of Medicine

Carly E. Souther, J.D., Legal Research Assistant

Endorsed by:
Winter Park Health Foundation
220 Edinburgh Dr.
Winter Park, FL, 32792
www.wphf.org

Commissioned by:
Health Foundation of South Florida
Steven E. Marcus, Ed.D., President and CEO
One Biscayne Tower
2 South Biscayne Boulevard
Suite 1710
Miami, Florida 33131
www.hfsf.org

Endnotes

[1] Public Law 93-641, 88 Stat. 2225.
[2] Yakima Valley Memorial Hospital v. Washington State Department of Health, No. 12-35652 (9th Cir. Sept. 23, 2013). *But see* Colon Health Centers of America v. Washington Imaging Associates-Maryland, No. 12-2272 (U.S. 4th Cir. Oct. 23, 2013) (raising issues about CON and antitrust laws).
[3] Laws of Florida, Ch. 2013-153 (June 7, 2013).
[4] *New Florida Law to Allow More Nursing Home Beds in The Villages*, THE NURSING HOME MONITOR (June 11, 2013), available at http://www.nhmonitor.com/2013/06/new-florida-law-to-allow-more-nursing-home-beds-in-the-villages/ (last accessed Oct. 7, 2013).
[5] Mary Ellen Klas & Daniel Chang, *Legislature Opens Door to Giving Miami Children's Hospital Maternity Ward*, MIAMI HERALD (Apr. 18, 2013), available at http://www.miamiherald.com/2013/04/18/3352232/legislature-opens-door-to-giving.html (last accessed Oct. 7, 2013).
[6] Fla. Stat. § 408.034(3).
[7] Florida Hospital Association, *Certificate of Need*, available at http://www.fha.org/advocacy/state-advocacy/legislative-issues/certificate-of-need.aspx (last accessed Oct. 7, 2013); *Competition and Health Care Costs*, HEALTH ISSUES BRIEF, Florida Hospital Government and Public Affairs: Orlando, FL (Sept. 2013).
[8] Florida Health Care Association, *Support Certificate of Need Reforms that Meet Long Term Care Resident Needs and Promote Nursing Facility Modernization*, available at http://www.fhca.org/images/uploads/pdf/CONTalkPaper.pdf (last accessed Oct. 7, 2013); Leading Age Florida [awaiting materials following their upcoming Board meeting]
[9] 42 U.S.C. § 1395dd.
[10] Fla. Stat. § 395.1041.
[11] Fla. Stat. § 400.022 (1) (p).
[12] American Health Planning Association, *Inproving Health Care: A Dose of Competition; AHPA Response*, available at http://www.ahpanet.org/files/AHPAargfavorCON.pdf (last accessed Oct. 7, 2013).
[13] Frances Leslie Lucas, Andrea Siewers, David C. Goodman, Dongmei Wang, & David E. Wennberg, *New Cardiac Surgery Programs Established from 1993 to 2004 Led to Little Increased Access, Substantial Duplication of Services*, HEALTH AFFAIRS 30(8):1569-1574 (Aug. 2011).
[14] H.B. 329, 106th Gen. Assem., Reg. Sess., FL 2004.
[15] G. Chad Hughes, Yue Zhoa, J. Scott Rankin, John E. Scarborough, Sean O'Brien, Joseph E. Bavaria, Walter G. Wolfe, Jeffrey G. Gaca, James S. Gammie, David M. Shahian, & Peter K. Smith, *Effects of Institutional Volumes on Operative Outcomes for Aortic Root Replacement in North America*, JOURNAL OF THORACIC AND CARDIOVASCULAR SURGERY 145(1):166-170 (Jan. 2013).
[16] Public Law No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152, 124 Stat. 1029 (2010).

[17] Clark C. Havighurst, *Monopoly is Not the Answer*, HEALTH AFFAIRS Web Exclusive W 5-373 (Aug. 9, 2005); Timothy Sandefur, *CON Job: State "Certificate of Necessity" Laws Protect Firms, Not Consumers*, REGULATION 42-46 (Summer 2011).
[18] United Network for Organ Sharing, www.unos.org (last visited Oct. 7, 2013).
[19] Charlene Wear Simmons, *Hospital Planning: What Happened to California's Certificate of Need Program?* Sacramento, CA: California Research Bureau, CRB 06-009 (2006).
[20] Indu Rekha Meesa Robert A. Meeker, & Suresh K. Mukherji, *Certificate of Need*, NEUROIMAGING CLINICS OF NORTH AMERICA 22:443-450 (2012).
[21] *Competition and Health Care Costs*, supra Note 11.
[22] *Competition and Health Care Costs*, supra Note 11.
[23] Atul Gawande, *The Cost Conundrum*, NEW YORKER 36 (June 1, 2009).
[24] T.M. Piper, *Certificate of Need: Protecting Consumers' Interests*. Presentation on behalf of the American Health Planning Association to the Federal Trade Commission-Department of Justice Hearing on Health Care Competition, Quality, and Consumer Protection: Market Entry. Washington, DC (June 10, 2003), cited in Meesa, Meeker, & Mukherji, supra Note 20.
[25] Fla. Stat. § 429.07.

STATES WITH CON PROGRAMS (2011)

State/District with CON Programs	Dates of Programs	Certificate of Need Contact Information	Individual CON Websites
Alabama	1979-present	James E. Sanders, Deputy Director Phone: 334-242-4103 Fax: 334-242-4113 james.sanders@shpda.alabama.gov	http://www.shpda.state.al.us News Article: AL: Bill introduced in Alabama House that would abolish the Certificate of Need process for health services 2/12/09.
Alaska	1976-present	Karen Lawfer, CON Coordinator Phone: 907-465-8616 Fax: 907-465-6861 Karen.Lawfer@alaska.gov	Alaska's Certificate of Need Program
Arizona	1971-1985		No CON Program; see planning agency below
Arkansas	1975-present	Deborah Frazier, Director Phone: 501-661-2509 Fax: 501-661-2399 Deborah.Frazier@Arkansas.gov	http://www.arhspa.org
California	1969-1987		No CON Program; see planning agency below
Colorado	1973-1987		No CON Program; see planning agency below
Connecticut	1973-present	Melanie Dillman, Director, CON & Compliance Phone: 860-418-7060 Fax: 860-418-7053 melanie.dillman@ct.gov	Connecticut's Certificate of Need Program
Delaware	1978-present	Francis Osei-Afriyie, Management Analyst Phone: 302-744-4555 Fax: 302-739-3313 francis.osei-afriyie@state.de.us	Delaware's Certificate of Public Review Program
District of Columbia	1977-present	Vacant, Chief, Project Review Phone: 202-442-5875 Fax: 202-442-4822	DC Certificate of Need Website
Florida	1973-present	Jeff Gregg, Bureau Chief Phone: 850-412-4402 Fax: 850-413-7955 jeffrey.gregg@ahca.myflorida.com	Florida Licensing and Certification
Georgia	1979-present	Marsha Hopkins, Executive Director Phone: 404-656-0468 Fax: 404-656-0654 mhopkins@dch.ga.gov	Georgia's Certificate of Need Program
Hawaii	1974-present	Darryl Shutter, Regulatory Branch Chief Phone: 808-587-0788 Fax: 808-587-0783 darryl.shutter@shpda.org	Hawaii's website for Certificate of Need
Idaho	1980-1983	They are attempting to pass CON legislation; Contact Steve Millard or Toni Lawson 208-338-5100 or sammillard@teamiha.org, tlawson@teamiha.org	No CON Program; see planning agency below

Illinois	1974-present	Courtney Avery, Administrator Phone: 312 814-4825 Fax 312 814-1503 courtney.avery@illinois.gov	http://www.hfsrb.illinois.gov
Indiana	1980-1996, 1997-1999		No CON Program; see planning agency below
Iowa	1977-present	Barb Nervig, Program Manager Phone: 515-281-4344 Fax: 515-281-4958 bnervig@idph.state.ia.us	http://www.idph.state.ia.us/do/cert_of_need.asp
Kansas	1972-1985		No CON Program; see planning agency below
Kentucky	1972-present	Shane O'Donley, Policy Advisor Phone: 502-564-9589 Fax: 502-564-0302	http://chfs.ky.gov/ohp/con
Louisiana	1991-present	James Taylor, Facility Need Review Manager Phone: 225-342-5457 Fax: 225-342-3893 jhtaylor@dhh.la.gov	http://www.dhh.state.la.us/
Maine	1978-present	Phyllis Powell, Manager Division of Licensure & Regulatory Services Phone: 207-287-9338 fax: 207-287-5807 Phyllis.Powell@maine.gov	Maine Certificate of Need Program
Maryland	1968-present	Paul Parker, Chief Phone: 410-764-3261 Fax: 410-358-1311 pparker@mhcc.state.md.us	Maryland Certificate of Need Program
Massachusetts	1972-present	Joan Gorga, Director Phone: 617-753-7340 Fax: 617-753-7349 Joan.Gorga@state.ma.us	http://www.state.ma.us/dph/dhcq/don.htm
Michigan	1972-present	Scott Blakeney, Manager Phone: 517-241-3344 Fax: 517-241-2962 blakeneys@michigan.gov	http://www.michigan.gov/con The Michigan Certificate of Need Program (68 pp)- an in-depth analysis by CRC-Michigan
Minnesota	1971-1985	Public Utilities Commission (PUC) of Minnesota Bret Eknes, Senior Facility Planner Phone: 651-201-2236 Fax: 651-297-7073	Minnesota Certificate of Need Program
Mississippi	1979-present	Rachel Pittman, Chief Phone: 601-576-7874 Fax: 601-576-7530 rachel.pittman@msdh.state.ms.us	Mississippi Certificate of Need Program
Missouri	1979-present	Karla Houchins, Program Coordinator Phone: 573-751-6403 Fax: 573-751-7894 Karla.Houchins@health.mo.gov	http://health.mo.gov/information/boards/certificateofneed/index.php
Montana	1975-present	Kathy Lubke, Project Manager Phone: 406-444-9519 Fax: 406-444-1742 klubke@mt.gov	Administrative Rules of Montana CON

Nebraska	1979-present	Claire Titus, Program Manager Phone: 402-471-4963 Fax: 402-471-3577 claire.titus@nebraska.gov	http://www.hhs.state.ne.us/crl/need.htm
Nevada	1971-present	Luana J. Rich, Bureau Chief Phone: 775-684-4155 Fax: 775-684-4156 lritch@health.nv.gov	http://www.health2k.state.nv.us/vs/letter.htm
New Hampshire	1979-present	Cynthia Carrier, Managing Analyst Phone: 603-271-4606 Fax: 603-271-4141 ccarrier@dhhs.state.nh.us	http://www.nhha.org/nhha/state_law/con.php
New Jersey	1971-present	John Calabria, Director Phone: 609-292-8773 Fax: 609-292-3780 john.calabria@doh.state.nj.us	http://www.state.nj.us/health/forms/cn-7.pdf
New Mexico	1978-1983		No CON Program; see planning agency below
New York	1966-present	Christopher Delker, Program Research Specialist Phone: 518-402-0966 Fax: 518-402-0971 cpd02@health.state.ny.us	http://www.health.state.ny.us/nysdoh/cons/index.htm
North Carolina	1978-present	Craig Smith, Chief Phone: 919-855-3873 Fax: 919-733-8139 craig.smith@dhhs.nc.gov	http://facility-services.state.nc.us/
North Dakota	1971-1995		No CON Program
Ohio	1975-present	Joel Kaiser, CON Director Phone: 614-466-3325 Fax: 614-752-4157 joel.kaiser@odh.ohio.gov	Ohio CON webpage
Oklahoma	1971-present	Darlene Simmons, Director Phone: 405-271-6868 Fax: 405-271-7360 darlen@health.state.ok.gov	Oklahoma CON Abstract
Oregon	1971-present	Jana Fussell, CON Coordinator Phone: 971-673-1108 Fax: 971-673-1299 jana.fussell@state.or.us	Oregon CON Webpage
Pennsylvania	1979-1996		No CON Program; see planning agency below
Puerto Rico	1975-present		
Rhode Island	1968-present	Michael K. Dexter, Chief, Office of Health Systems Development Phone: 410-222-2788 Fax: 410-222-1797 michael.dexter@health.ri.gov	http://www.health.ri.gov/hsr/healthsystems/index.php
South Carolina	1971-present	Beverly A. Brandt, Chief Phone: 803-545-4200 Fax: 803-545-4579 brandtba@dhec.sc.gov	http://www.scdhec.gov/hr/cofn/
South Dakota	1972-1988		No CON Program; see planning agency below
Tennessee	1973-present	Melanie M. Hill, Executive Director Phone: 615-741-2364 Fax: 615-741-9884 melanie.hill@tn.gov	http://tennessee.gov/hsda/cert_need_sum.html

Texas	1975-1985		No CON Program; see planning agency below
Utah	1979-1984		No CON Program; see planning agency below
Vermont	1979-present	Donna Jerry, Health Policy Analyst Phone: 802-828-2900 Fax: 802-828-2949 donna.jerry@bishca.state.vt.us	Vermont CON program
Virginia	1973-present	Erik Bodin, Director Phone: 804-367-2126 Fax: 804-527-4501 erik.bodin@vdh.virginia.gov	http://www.cvhpa.org/COPN.htm
Washington	1971-present	Janis Sigman, Manager Phone: 360-236-2956 Fax: 360-236-2901 janis.sigman@doh.wa.gov	Washington CON program
West Virginia	1977-present	Timothy E. Adkins, CON Director Phone: 304-558-7000 Fax: 304-559-7001 tadkins@hcawv.org	http://www.hcawv.org/CertOfNeed/conHome.htm
Wisconsin	1977-1987, 1993-2011		No CON Program
Wyoming	1977-1989		No CON Program; see planning agency below

HEALTH
FOUNDATION
of south florida

2 South Biscayne Boulevard
Suite 1710, Miami, FL 33131
P 305.374.7200